



Key Physician Provisions

Coronavirus Aid, Relief, and Economic Security (CARES) Act

The *Coronavirus Aid, Relief, and Economic Security (CARES) Act* had a series of provisions, which may be of interest to physicians. The final bill text is [here](#), with the appropriations summary (Division B) from Republicans [here](#) and Democrats [here](#), unemployment/retirement summary [here](#), Finance Committee health provisions summary [here](#), HELP Committee summary [here](#), HELP Committee one pager [here](#), Small Business Committee summary [here](#), and one pager [here](#).

Paycheck Protection Program and Health Care Enhancement Act

The *Paycheck Protection Program and Health Care Enhancement Act* added \$75 billion to the CARES Act Provider Relief Fund.

Key Provisions

Small business relief

There are two main provisions to provide relief to physicians, physician practices, and (in some instances) physician professional organizations: (1) Paycheck Protection Program; and (2) CARES Act Provider Relief Fund.

Paycheck Protection Program

Paycheck Protection Program (PPP) provides a forgivable loan option for certain small businesses. For more information, visit [here](#) (SBA resource), [here](#) (Hart Health resource), and [here](#) (Hart Health FAQ).

CARES Act Provider Relief Fund

Division B of the *CARES Act* includes key language related to an initial \$100 billion for health care services related to the COVID-19.¹ Specifically, the funds are “to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus.” The funds may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

The *Paycheck Protection Program and Health Care Enhancement Act* added \$75 billion to the CARES Act Provider Relief Fund, while the *Consolidated Appropriations Act, 2021* added \$3 billion to the Fund and provided a few other changes to the program.

¹ Key language begins on p. 750.

HHS and Other Announcements

On April 3, during the Task Force press conference, Secretary Azar noted that a portion of the \$100 billion provided to the Public Health and Social Services Fund for health care providers in the CARES Act would be allocated to cover the cost of the treatment for the uninsured. Such funding would be through the same mechanism as COVID-19 testing. As a condition of receiving the funds, providers would have to agree not to balance bill, and the reimbursement rates would be set at Medicare rates. The Secretary further noted that additional specifics regarding the rest of the funds would be forthcoming.

On April 7, 2020, CMS Administrator Seema Verma noted that \$30 billion of the \$100 billion fund through the PHSSEF for health care providers, \$30 billion will be available via grants, based on Medicare revenue, and such funds will NOT be on a first come, first serve basis. To receive the funds, providers will need to register with CMS. Money can be direct deposited. She acknowledged that certain providers (e.g., pediatricians, OB/Gyns, etc.) do not serve a large portion of the Medicare population. As such, CMS will address those issues in the second wave of funding from the fund. During that announcement, there was no discussion regarding the uninsured.

On April 10, 2020, HHS issued information regarding the \$30 billion, including a [press release](#), a [fact sheet](#), and [Terms and Conditions](#).² Providers will be distributed a portion of the initial \$30 billion based on their share of total Medicare FFS reimbursements in 2019. Many health care providers received the funds on April 10. Within 30 days of receipt of the funds, a provider must attest to receiving the funds and agree to the Terms and Conditions. Otherwise, the provider needs to contact HHS and then remit the full payment as instructed. HHS has subsequently clarified that not returning the payment within 30 days of receipt will be viewed as acceptance of the Terms and Conditions. HHS subsequently released data on the \$30 B distribution of the funds by [State](#) and [Congressional district](#). In addition, the House Ways and Means Committee Republicans issued information, including a [fact sheet](#), [FAQ](#), and information on the amount of [funds](#) to each State.

On April 16, 2020, the [CARES Act Provider Relief Fund Payment Attestation Portal](#) went live. The portal has a variety of steps, including confirmation of eligibility, billing TINs, verifying payment information, attestations (likely related to the Terms and Conditions), and confirmation.

On April 22, 2020, HHS [announced](#) additional allocations through the CARES Act Provider Relief Fund.

On May 1, 2020, HHS [announced](#) the distribution of \$10 billion to 395 hospitals who provided inpatient care for 100 or more COVID-19 patients through April 10, 2020, and will distribute an additional \$2 billion to these hospitals based on their Medicare and Medicaid disproportionate share and uncompensated care payments. Also on May 1, HHS [announced](#) the distribution of \$10 billion rural distribution will include, rural acute care general hospitals and Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Community Health Centers located in rural areas.

On May 7, 2020, HHS [announced](#) that it would extend the deadline for attestation, acceptance of the terms and conditions for the fund to 45 days (from the previous 30 days). On that same day, Energy and Commerce Chairman Frank Pallone, Jr. (D-NJ) and Ways and Means Chairman Richard E. Neal (D-MA) sent a [letter](#) to Health and Human Services (HHS) Secretary Alex Azar and Centers for Medicare & Medicaid Services (CMS) Administrator Seema

² The Terms and Conditions have been updated at least three times – on April 13, April 20, and April 24. Therefore, the ensuing discussion focuses on the latest Terms and Conditions. However, these Terms and Conditions have changed and may change again.

Verma today raising a series of concerns over the methodology used to distribute and the lack of transparency into how COVID-19 relief funds and loans for health care providers are being spent.

On May 13, 2020, Energy and Commerce Committee Subcommittee on Health Republican Leader Dr. Michael Burgess (R-TX) sent a [letter](#) to Subcommittee Chairwoman Anna Eshoo (D-CA) to ask for a hearing on how funds are being distributed to providers from Provider Relief Fund.

On May 20, 2020, HHS [issued](#) a press release reminding eligible providers that they have until June 3, 2020, to accept the Terms and Conditions and submit their revenue information to support receiving an additional payment from the Provider Relief Fund \$50 billion General Distribution. Also on May 20, HHS [announced](#) the distribution of funding to rural health clinics for testing.

On May 22, 2020, HHS [announced](#) it has begun distributing \$4.9 billion in additional relief funds to skilled nursing facilities (SNFs) to help them combat the devastating effects of this pandemic. That same day, HHS [announced](#) a 45-day extension for providers who are receiving payments from the Provider Relief Fund to accept the Terms and Conditions for Provider Relief Fund payments. This announcement means providers have now been granted 90 days from the date they received a payment to accept HHS Terms and Conditions or return the funds. On May 22, HHS [announced](#) a \$500 M distribution to tribal hospitals, clinics, and urban health centers.

On May 29, 2020, Representative Lloyd Doggett (D-TX), Chair of the House Ways and Means Health Subcommittee, and Representative Katie Porter (D-CA), member of the Committee on Oversight and Reform, sent a [letter](#) to HHS, noting concerns that funds had been distributed to “hospitals previously closed, mega-corporations, and possible fraudsters.”

On June 3, 2020, House Energy and Commerce Chairman Frank Pallone, Jr. (D-NJ), House Energy and Commerce Ranking Member Greg Walden (R-OR), Senate Finance Chairman Charles E. Grassley (R-IA) and Senate Finance Ranking Member Ron Wyden (D-OR) sent a [letter](#) to HHS voicing concerns that funds has not yet been allocated to Medicaid providers.

On June 9, 2020, HHS [announced](#) additional distributions from the Provider Relief Fund to eligible Medicaid and Children's Health Insurance Program (CHIP) providers that participate in state Medicaid and CHIP programs. HHS expects to distribute approximately \$15 billion to eligible providers that participate in state Medicaid and CHIP programs and have not received a payment from the Provider Relief Fund General Allocation. HHS also announced the distribution of \$10 billion in Provider Relief Funds to safety net hospitals that serve our most vulnerable citizens. The safety net distribution will occur this week. On June 10, several members of Congress [commended](#) HHS for “taking the first steps to address the needs of Medicaid-dependent providers by [awarding](#) about \$25 billion to providers with vulnerable patient populations. The Committee leaders reiterated, however, that more needs to be done to address the ongoing needs of large numbers of Medicaid-dependent providers that will not benefit from yesterday’s announcement.” On July 17, HHS [announced](#) an extension of the deadline to apply for the Medicaid and CHIP allocation – to August 3 as well as noting that the \$10 billion in “hot spot” funds would begin distribution on July 20.

On July 10, 2020, HHS [announced](#) \$4 billion in additional distributions, including to \$3 billion in funding to hospitals serving a large percentage of vulnerable populations on thin margins and approximately \$1 billion to specialty rural hospitals, urban hospitals with certain rural Medicare designations, and hospitals in small metropolitan areas. HHS also stated that it is opening the provider portal to allow dentists to apply for relief.

On July 22, 2020, CMS (not HHS) [announced](#) \$5 billion in additional distributions to nursing homes. On August 7, HHS officially [announced](#) additional details regarding the distribution.

On July 31, 2020, HHS [announced](#) the extension of key deadlines for certain providers until August 28 (i.e., Medicaid, CHIP, and dental), the reopening of the portal for the General Distribution (from the week of August 10 until August 28), the initial opening of the portal for certain providers who have changed ownership (from the week of August 10 until August 28), and additional providers who will receive distributions (e.g., those that “may only bill commercially, or do not directly bill for the services they provide under the Medicare and Medicaid programs and thus did not receive any funding yet”).

On August 10, 2020, the Department of Health and Human Services (HHS) [announced](#) that the Provider Relief Fund portal would be open to additional applicants for a portion of the General Distribution funding. Specifically, new applicants include:

- Providers who were ineligible for the Phase 1 General Distribution because:
 - They underwent a change in ownership in calendar year 2019 or 2020 under Medicare Part A; and
 - Did not have Medicare Fee-For-Service revenue in 2019.
- Providers who received a payment under Phase 1 General Distribution but:
 - Missed the June 3 deadline to submit revenue information – including many Medicaid, CHIP, and dental providers with low Medicare revenues that assumed they were ineligible for additional distribution targeted at Medicare providers or had planned to apply for a Medicaid and CHIP specific distribution; or
 - Did not receive Phase 1 General Distribution payments totaling approximately 2 percent of their annual patient revenue.
- Providers who previously received Phase 1 General Distribution payment(s) but rejected and returned the funds and are now interested in reapplying.

These additional applicants will have until August 28 to apply. *Note: Recent updates to the HHS website suggest that this deadline has been extended until September 13.*

On August 14, 2020, HHS [announced](#) an additional \$1.4 billion in targeted distribution funding to almost 80 free-standing children’s hospitals nationwide.

On August 26, 2020, CMS [released](#) an additional list of Frequently Asked Questions (FAQs) to Medicare providers regarding the Department of Health & Human Services’ (HHS) Provider Relief Fund and the Small Business Administration’s Paycheck Protection Program payments. The FAQs provide guidance to providers on how to report provider relief fund payments, uninsured charges reimbursed through the Uninsured Program administered by Health Resources and Services Administration, and Small Business Administration (SBA) Loan Forgiveness amounts. The FAQs also address that provider relief fund payments should not offset expenses on the Medicare Cost Report.

On August 27, 2020, HHS [announced](#) that \$2.5 billion of the set aside of \$5 billion had been allocated to nursing homes, with an additional \$2 billion slated for distribution this fall.

In August 2020, the HHS OIG [updated](#) its work plan to include an audit of CARES Act Provider Relief Funds—General and Targeted Distributions to Hospitals.

On September 1, 2020, HHS [announced](#) that assisted living facilities could now apply for funding under the Provider Relief Fund Phase 2 General Distribution allocation, with an application deadline of September 13.

On September 3, 2020, HHS [announced](#) information related to \$2 billion incentive payment of the set aside of \$5 billion that had been allocated to nursing homes (see August 27 announcement).

On October 1, 2020, HHS [announced](#) an additional \$20 billion in General Distribution allocation for “for additional funding that considers financial losses and changes in operating expenses caused by the coronavirus,” also known as “Phase 3” funding. To submit the application, visit [here](#), and HHS has detailed the general process for applying [here](#), including [application instructions](#) and [sample application form](#). In addition, HHS has recently posted a [fact sheet](#) and [presentation](#).

On October 5, 2020, HHS updated its PRF [FAQs](#), providing some additional clarity regarding Phase 3 with respect to the overall formula for the add-on payment, the timing for receipt of any add-on payment, key definitions related to Phase 3 distribution, and how long a provider would have to account for the use of the funds in order to retain them. The FAQs note that the add-on payment will “take into account a provider’s change in operating revenues from patient care, minus their operating expenses from patient care” as well as previous PRF distributions (including Targeted Distributions). Given that HHS will not be able to calculate the add-on payments until after all applications have been submitted and that HHS has further clarified that the first payments from Phase 3 will focus on ensuring providers first receive their 2% allocation, the add-on payment amount will not be distributed until well after the application deadline. The FAQs also note that the focus is health care expenses attributable to the virus and lost revenues *from patient care*, similar to the what is included within the reporting requirements. In particular, this differs from some of the other General Distribution funding, which allowed providers greater flexibility in determining lost revenue. Finally, the FAQs note, that while the Phase 3 application only takes into account the first and second quarters of 2020, a provider will have until the end of the second quarter of 2021 to fully account for any funds received.

On October 8, 2020, CMS [issued](#) an announcement related to the accelerated and advanced payment program. As part of that announcement, CMS noted that “[t]o allow even more flexibility in paying back the loans, the \$175 billion issued in Provider Relief funds can be used towards repayment of these Medicare loans.” Subsequent to that announcement on October 9, HHS updated its FAQs³ noting that this was not a permissible use of funds. In light of that FAQ, the CMS announcement was reviewed, and the key language noted above was deleted, without any indication on the announcement when the update was made.

On October 22, 2020, HHS [announced](#) expanded eligibility for the Phase 3 General Distribution, along with revisions to the reporting requirements. Specifically, as detailed in a separate [memo](#), HHS described the rationale for the reporting requirement changes, noting that the “decision to prohibit most providers from using PRF payments to become more profitable than they were pre-pandemic, in order to conserve resources to allocate to providers who were less profitable, has generated significant attention and opposition from many stakeholders and Members of Congress. There is consensus among stakeholders and Members of Congress who have reached out to HHS that the PRF should allow a provider to apply PRF payments against all lost revenues without limitation. In consideration of this feedback, HHS has amended its reporting instructions to provide for the full applicability PRF distributions to lost revenues.” The [revised](#) reporting requirements state that “[r]ecipients may apply PRF

³ Full FAQ as follows:

Can providers use Provider Relief Fund distributions to repay payments made under the CMS Accelerated and Advance Payment (AAP) Program? (Added 10/9/2020)

No, this is not a permissible use of Provider Relief Fund payments.

payments toward lost revenue, up to the amount of the difference between their 2019 and 2020 actual patient care revenue.” This differs from the [initial](#) reporting requirements which focused on net profit.

On October 27, 2020, the HHS Office of the Inspector General (OIG) [updated](#) its work plan to include items related to the PRF. Specifically, the updated workplan includes an audit of the [\\$50 B General Distribution](#) as well as the [uninsured distribution](#).

On October 28, 2020, HHS [announced](#) the distribution of additional funds to nursing homes.

On November 2, 2020, HHS updated its [FAQs](#) and [Reporting Requirements](#) clarifying that, with respect to the calculation on funds being retained “healthcare related expenses are no longer netted against the patient care lost revenue amount in Step 2.”

On December 7, 2020, HHS [announced](#) an additional \$0.5 B distribution to nursing homes in the form of an incentive payment.

On December 16, 2020, HHS [announced](#) the Phase 3 General allocation distribution. While the original allocation was for \$20 B, HHS increased the total to \$24.5 B so that all health care providers could receive “up to 88 percent of their reported losses,” taking into account prior distributions. Distribution of the additional funding to 70,000 providers began immediately and will continue through January.

On December 27, 2020, the President signed the *Consolidated Appropriations Act, 2021*, which among other things, included \$3B for the Provider Relief Fund, along with additional language: (1) clarifying that a parent organization can transfer funds to a subsidiary (under certain circumstances, even for Targeted Distributions), (2) describing how a provider may calculate lost revenues (i.e., that the provider may use the calculation using the FAQ guidance from June 2020, including the difference between such provider’s budgeted and actual revenue budget if such budget had been established and approved prior to March 27, 2020), and (3) specifying that not less than 85 percent of the unobligated balances available as of December 27, and any funds recovered from health care providers after December 27, shall be for any successor to the Phase 3 General Distribution allocation to make payments to eligible health care providers based on applications that consider financial losses and changes in operating expenses occurring in the third or fourth quarter of calendar year 2020, or the first quarter of calendar year 2021. As part of the updates to the FAQs on December 28, HHS noted that the calculation for determining the payment amount for Phase 3 was (1) 2% of annual revenue from patient care, if such funds had not already been received in Phase 1 or 2; and (2) up to 88 percent of their reported losses and net change in their operating expenses from patient care from the first half of 2020. Given the change to calculation of lost revenue, which primarily applies to the Reporting Requirements, the reporting portal, which was scheduled to be available by mid-January of 2021, may be further delayed.

On January 15, 2021, HHS updated its website to (1) revise information on the [reporting elements](#); and (2) clarify that the Reporting Portal is open *but only for registration*. Given the lack of full functionality to the Reporting Portal, the initial reporting deadline was removed (i.e., February 15 deadline for the first report). According to a new [FAQ](#), HHS will announce the window for submitting the first report. Recipients with funds unexpended after December 31, 2020, have six more months from January 1 – June 30, 2021 to use remaining funds, and then must submit a second and final report no later than July 31, 2021. With respect to the new [Reporting Portal](#), HHS has issued a series of [FAQs](#) and a [Registration User Guide](#). According to those documents, registration should take approximately 20 minutes and must be completed within one session.

On May 3, HHS [announced](#) a new reimbursement program – the COVID-19 Coverage Assistance Fund (CAF) -- for COVID-19 administration fees not covered by insurance. Funded through the Provider Relief Fund Program, the CAF program will accept eligible claims from providers dated on or after December 14, 2020. For more information and the claims submission [portal](#), visit [here](#).

To assist with distributing the funds, HHS has contracted with UnitedHealth Group. For questions regarding the distribution of funds, please call the toll-free CARES Provider Relief line at 866-569-3522.

The chart below summarizes the information to date on the various distributions.

Target Group	Funding allocation	Formula	Distribution Timeline	Additional processes
GENERAL DISTRIBUTION				
General Allocation	\$74.5 B	<p>\$30 B proportionately based on Medicare FFS in 2019</p> <p>\$20 B to reconcile the initial payment (if any) so that the provider ultimately receives a proportion of a provider's 2018 patient revenue</p> <p>\$24.5 B so that a provider would receive "up to 88 percent of their reported losses"</p>	<p>April 10 (\$26 B) – 17 (\$4B)</p> <p>April 24 for initial distribution (around \$10B)</p> <p>Applications available Oct. 5 – Nov. 6; Providers encouraged to apply early; Distribution announcement on December 15</p>	<p>Physicians had to sign into the General Distribution Portal and submit relevant information to receive additional funds (from the \$20 B initial distribution and the \$20 B add-on payment).</p> <p>For a listing of providers (aligned with billing TIN) who has received at least one payment from the General Distribution to which they have attested, visit here.</p> <p>A state-by-state breakdown on the first batch of Phase 3 payments can be found here - PDF. This data will be updated through January as Phase 3 payments are completed.</p> <p>Terms and Conditions: Relief Fund Payment from \$30 Billion General Distribution - PDF Relief Fund Payment \$20 Billion General Distribution - PDF Phase 3 General Distribution Relief Fund Terms and Conditions - PDF</p>
Medicaid & CHIP	\$15 B	At least 2% of reported gross revenue from patient care; the final amount each provider receives will be determined after the data is submitted, including information about the number of Medicaid patients providers serve.	Announcement on June 9, with applications deadline of September 13 (deadline extended on July 17 and 31)	<p>Link to Terms and Conditions.</p> <p>Read the Medicaid Provider Distribution Instructions - PDF.</p> <p>Download the Medicaid Provider Distribution Application Form - PDF.</p> <p>Medicaid, Medicaid managed care, CHIP and Dentist Provider Relief Fund Payment Terms and Conditions - PDF</p>
Dentists	TBD	2% of annual reported patient revenue	Announcement on July 10; applications deadline of September 13 (deadline extended).	Medicaid, Medicaid managed care, CHIP and Dentist Provider Relief Fund Payment Terms and Conditions - PDF
Assisted Living Facilities	TBD	2% of annual reported patient revenue	Announcement on September	Phase 2 General Distribution Relief Fund Payment Terms and Conditions - PDF

Target Group	Funding allocation	Formula	Distribution Timeline	Additional processes
			1; September 13 deadline.	
Additional allocations	TBD	TBD	TBD	There are some providers who will receive further, separate funding, including those that “may only bill commercially, or do not directly bill for the services they provide under the Medicare and Medicaid programs.” (July 31 announcement)
TARGETED DISTRIBUTIONS				
“Hot Spots”	Initial \$12 B \$10 B	For hospitals with 100 or more COVID-19 admissions between January 1 and April 10, 2020, \$76,975 per eligible admission, along with a DSH adjustment. For hospitals with over 161 COVID-19 admissions between January 1 and June 10, 2020, or one admission per day, or that experienced a disproportionate intensity of COVID admissions (exceeding the average ratio of COVID admissions/bed), \$50,000 per eligible admission.	Announcement on May 1 Notice to hospitals on June 8; announcement on June 9; data due June 15. Distribution beginning July 20.	For facilities only at this time. Therefore, not as relevant to physicians. For a State breakdown of the first round, visit here . Link to the Terms and Conditions, methodology , State and county distribution , and list of providers who received the funds. View the current list of hospital recipients. View a state-by-state breakdown on funding. - PDF
Rural providers	\$11 B (\$10 B initially + \$1 B)	Proportionately based on operating expenses	Announcement on May 1 and July 11	For facilities only at this time. Therefore, not as relevant to physicians. For a state-by-state breakdown, visit here . Link to the Terms and Conditions .
Indian Health	\$500 M	Proportionately based on operating expenses	Announcement on May 22	For facilities only at this time. Therefore, not as relevant to physicians. Link to the Terms and Conditions .
Rural Health Testing	\$225 M	n/a	Announcement on May 20	For facilities only. Therefore, not as relevant to physicians. Link to Terms and Conditions and State-by-State breakdown .
Nursing homes	\$10.4 B (\$4.9 B initially + \$5 B + \$0.5 B)	Initial formula = \$50,000, plus a distribution of \$2,500 per bed for all certified SNFs with six or more certified beds; Additional distributions by various formulas.	Announcement on May 22, July 22, August 27, September 3, October 28, and December 7	For facilities only. Therefore, not as relevant to physicians. Link to Terms and Conditions and State-by-State breakdown .
Safety Net Hospitals	\$13 B (\$10 B initially + \$3B)	For hospitals that serve a disproportionate number of Medicaid patients or provide large amounts of uncompensated care	Announcement on June 9 and July 10	For facilities only at this time. Therefore, not as relevant to physicians. Link to Terms and Conditions and State-by-state breakdown - PDF
Freestanding Children’s Hospitals	\$1.4 B	2.5% of general patient revenue	Announcement on August 14	For facilities only at this time. Therefore, not as relevant to physicians.

Target Group	Funding allocation	Formula	Distribution Timeline	Additional processes
				Link to Terms and Conditions and State-by-State breakdown .
UNINSURED				
Uninsured	Dependent on the claims received; \$10B*	Based on claims; paid at Medicare rates	Registration starting April 27	As announced in early April, a portion of the \$100 billion Provider Relief Fund will be used to reimburse healthcare providers, at Medicare rates, for COVID-related treatment of the uninsured. Every health care provider who has provided treatment for uninsured COVID-19 patients on or after February 4, 2020, can request claims reimbursement through the program and will be reimbursed at Medicare rates, subject to available funding. Steps will involve: enrolling as a provider participant, checking patient eligibility and benefits, submitting patient information, submitting claims, and receiving payment via direct deposit. As a condition, providers are obligated to abstain from "balance billing" any patient for COVID-19-related treatment. To receive the funds, an entity must agree to the Terms and Conditions for uninsured testing or uninsured care and treatment . On April 27, HHS provided the portal for the uninsured, along with a FAQ . For more information on the uninsured portions, see our summary here .
TOTAL ALLOCATIONS	~\$158.025 B			

*Not included in HHS' information but relayed by Hill staff regarding the intent.

Which Portal Should I use?

Given the number of portals included within the CARES Act Provider Relief Fund, see below for all of the relevant links and some general information.

Enhanced Provider Relief Payment Portal. On June 11, HHS launched the Enhanced Provider Relief Payment [Portal](#), primarily for providers who did not automatically receive funds during the first General Distribution process. This is the appropriate portal for Phase 3 funding.

Attestation Portal. To attest to the Terms and Conditions and to confirm receipt of these funds, visit the attestation [portal](#), which was launched April 16 and updated in early May.

Uninsured Claims Reimbursement Portal. To register and submit claims related to the uninsured, visit the uninsured claims reimbursement [portal](#), which was launched on April 27.

General Distribution Portal. Initial [portal](#) provided to assist with the General Distribution.

Reporting Portal. [Portal](#) for a provider to submit documentation to avoid recoupment of funds. Opened for registration on January 15, 2021.

Terms and Conditions and FAQs for the General Allocation

For the \$30 B allocation, the initial Terms and Conditions were provided on April 10 and updated on April 13, April 20, April 24, and early June. In comparing the latest version of the \$30 B Terms and Conditions to the initial Terms and Conditions for the \$20 B, the language is identical, except that the \$20 B Terms and Conditions includes additional language specific to the allocation.⁴

In reviewing the [Terms and Conditions](#), there are a few key items for providers to consider, as detailed below.

Possible or Actual cases. The provider must attest that s/he “provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19.” The initial terms and conditions did not include the specific date. While not included in the Terms and Conditions, HHS on its FAQs further notes that “HHS broadly views every patient as a possible case of COVID-19.” With the addition of the date and the HHS clarification, a provider may be able to attest to this requirement if s/he treated any patient after January 31, whether via telehealth or in-person.

Reallocating funds. At this time, there is not a process to allow an entity to reallocate the funds to different TIN in light of changes in ownership or new providers. This is a particular issue given that the legacy TINs may not be able to attest to the ability to treat patients and, as such, may have difficulty in attesting to retain the funds. To address this topic, HHS has updated its FAQs to attempt to provide additional clarity regarding evolving TINs.

Bans balanced billing. In essence, to retain the funds, a provider must not balance bill for “all care for a presumptive or actual case of COVID-19.”⁵ For those patients, the provider must not seek from the patient more than the patient would have been obligated to pay if the provider was an in-network provider. On May 6, HHS updated its FAQs to clarify that a “presumptive case” is “a case where a patient’s medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positive in vitro diagnostic test result in his or her medical record.” Further, the FAQs clarified that, if the insurer was not going to directly pay the provider for the patient’s cost-sharing requirements, then “the out-of-network provider may seek to collect from the patient out-of-pocket expenses, including deductibles, copayments, or balance billing, in an amount that is no greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.” On June 19, HHS further indicated that the “[s]ome Terms and Conditions relate to the provider’s use of the funds, and thus they apply until the provider has exhausted these funds.”⁶

⁴ The additional language is as follows: The Recipient shall also submit general revenue data for calendar year 2018 to the Secretary when applying to receive a Payment, or within 30 days of having received a Payment.

The Recipient consents to the Department of Health and Human Services publicly disclosing the Payment that Recipient may receive from the Relief Fund. The Recipient acknowledges that such disclosure may allow some third parties to estimate the Recipient’s gross receipts or sales, program service revenue, or other equivalent information.

⁵ The Secretary has concluded that the COVID-19 public health emergency has caused many healthcare providers to have capacity constraints. As a result, patients that would ordinarily be able to choose to receive all care from in-network healthcare providers may no longer be able to receive such care in-network. Accordingly, for all care for a presumptive or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network Recipient. (Language updated on April 20.)

⁶ Full FAQ is as follows:

For how long are the Terms and Conditions of the Provider Relief Fund applicable? (Added 6/19/2020)

All recipients receiving payments under the Provider Relief Fund will be required to comply with the Terms and Conditions. Some Terms and Conditions relate to the provider’s use of the funds, and thus they apply until the provider has exhausted

Use of funds. Another key requirement is that the “Recipient certifies that the Payment will only be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus.” This requirement is confusing at best, and it seems virtually impossible to use the fund *at the same time* for both care and lost revenue. Thankfully, on June 1 with additional revisions on June 22 and then again on October 28, HHS provided clarity on the use of funds through its FAQs. Specifically, HHS noted the following (with the June 22 and October 28 modifications in bold):

Please refer to the Post-Payment Notice of Reporting Requirements, released on September 19 and updated October, 22, 2020, and associated FAQs on reporting for the most current information on use of funds, as well as the definitions on health care-related expenses and lost revenue.

The term “healthcare related expenses attributable to coronavirus” is a broad term that may cover a range of items and services purchased to prevent, prepare for, and respond to coronavirus, including:

- *supplies used to provide healthcare services for possible or actual COVID-19 patients;*
- *equipment used to provide healthcare services for possible or actual COVID-19 patients;*
- *workforce training;*
- *developing and staffing emergency operation centers;*
- *reporting COVID-19 test results to federal, state, or local governments;*
- *building or constructing temporary structures to expand capacity for COVID-19 patient care or to provide healthcare services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated; and*
- *acquiring additional resources, including facilities, equipment, supplies, healthcare practices, staffing, and technology to expand or preserve care delivery.*

Providers may have incurred eligible health care related expenses attributable to coronavirus prior to the date on which they received their payment. Providers can use their Provider Relief Fund payment for such expenses incurred on any date, so long as those expenses were attributable to coronavirus and were used to prevent, prepare for, and respond to coronavirus. HHS expects that it would be highly unusual for providers to have incurred eligible expenses prior to January 1, 2020.

The term “lost revenues that are attributable to coronavirus” means any revenue that you as a healthcare provider lost due to coronavirus. This may include revenue losses associated with fewer outpatient visits, canceled elective procedures or services, or increased uncompensated care. Providers can use Provider Relief Fund payments to cover any cost that the lost revenue otherwise would have covered, so long as that cost prevents, prepares for, or responds to coronavirus. Thus, these costs do not need to be specific to providing care for possible or actual coronavirus patients, but the lost revenue that the Provider Relief Fund payment covers must have been lost due to coronavirus. HHS encourages the use of funds to cover lost revenue so that providers can respond to the coronavirus public health emergency by maintaining healthcare delivery capacity, such as using Provider Relief Fund payments to cover:

- *Employee or contractor payroll*

these funds. Other Terms and Conditions apply to a longer time period, for example, regarding maintaining all records pertaining to expenditures under the Provider Relief Fund payment for three years from the date of the final expenditure.

- Employee health insurance
- Rent or mortgage payments
- Equipment lease payments
- Electronic health record licensing fees

You may use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared. For example, if you have a budget prepared without taking into account the impact of COVID-19, the estimated lost revenue could be the difference between your budgeted revenue and actual revenue. It would also be reasonable to compare the revenues to the same period last year.

All providers receiving Provider Relief Fund payments will be required to comply with the reporting requirements described in the [Terms and Conditions](#) and specified in on HHS' website available at www.hhs.gov/providerrelief.

On July 31, HHS clarified in its FAQs that the funds must be used **by July 31, 2021**.⁷

Note: The reporting requirements (further discussed below) have a different methodology related to lost revenue. In light of that, providers should rely upon the requirements of the reporting requirements in lieu of the FAQs.

Not an exhaustive list. The Terms and Conditions include a statement that “[t]his is not an exhaustive list and you must comply with any other relevant statutes and regulations, as applicable.” Further, the notice states that “[n]on-compliance with any Term or Condition is grounds for the Secretary to recoup some or all of the payment made from the Relief Fund.”

Changing calculations for distribution. HHS initially distributed the funds based proportionately based on 2019 Medicare FFS but then later, according to the May 14 FAQ (which were further updated May 29 and June 12), opted to base it upon “at least 2% of that provider’s net patient revenue regardless of the provider’s payer mix. Payments are determined based **on the lesser of 2%** of a provider’s 2018 (or most recent complete tax year) net patient revenue or the sum of incurred losses for March and April. If the initial General Distribution payment you received between April 10 and April 17 was determined to be at least 2% of your annual patient revenue, you will not receive additional General Distribution payments.” (emphasis added to changed language) *Note: The FAQ suggests that it is net patient revenue, but subsequent FAQs (and the user guide) indicate that it is based on gross patient revenue.*⁸ The Phase 3 General Distribution was up to 88 percent of reported patient care revenue losses and COVID-related expenses.

⁷ Full FAQ reads as follows:

Is there a set period of time in which providers must use the funds to cover allowable expense or lost revenues attributable to COVID-19? (Modified 7/30/2020)

As explained in the notice of reporting requirements on the Provider Relief Fund website, reports on the use of Provider Relief Fund money must be submitted no later than July 31, 2021, and accordingly HHS expects that providers will fully expend their payments by that date. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately. All payment recipients must attest to the Terms and Conditions, which require the submission of documentation to substantiate that these funds were used for increased healthcare related expenses or lost revenue attributable to coronavirus.

⁸ Full FAQ reads as follows:

How can I estimate 2% of gross receipts or sales/program service revenue to determine my approximate General Distribution payment? (Modified 6/12/2020)

Subcontractors. Another key statement is that “[t]hese Terms and Conditions apply directly to the recipient of payment from the Relief Fund. In general, the requirements that apply to the recipient, also apply to subrecipients and contractors, unless an exception is specified.” The May 6 updates to the FAQ also further address this topic.⁹

Document internal conversations. Especially in light of the application of whistleblower protections, all internal conversations regarding the funds (especially as it relates to any ambiguities) should be well documented.

No other reimbursement. One additional requirement is that the “Recipient certifies that it will not use the Payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.” A recent FAQ sheds some light on the interaction of this program with other programs.¹⁰

In general, providers can estimate payments from the General Distribution of approximately 2% of 2018 (or most recent complete tax year) gross receipts or sales/program service revenue. To estimate your payment, use this equation: (Individual Provider Revenues/\$2.5 Trillion) X \$50 Billion = Expected Combined General Distribution.

Providers should work with a tax professional for accurate submission.

This includes any payments under the first \$30 billion General Distribution as well as under the \$20 billion General Distribution allocations. Providers may not receive a second distribution payment if the provider received a first distribution payment of equal to or more than 2% of gross receipts.

⁹ Full FAQ reads as follows:

If a hospital receives a Provider Relief Fund payment under the General, Rural or High Impact Distribution and the hospital contracts with an independently contracted provider (e.g., anesthesiologist or laboratory), is that independently contracted provider banned from balance billing for care provided to a “presumptive or actual COVID-19 patient”? (Modified 6/12/2020)

Yes, if the independently contracted provider also attested to receiving a payment from the Provider Relief Fund then the provider is banned from balance billing for care provided to a “presumptive or actual COVID-19 patient.”

¹⁰ Full FAQ reads as follows:

If a provider secures COVID-19-related funding separate from the Provider Relief Fund, such as the Small Business Administration’s Paycheck Protection Program, does that affect how they can use the payments from the Provider Relief Fund? Does accepting Provider Relief Fund payments preclude a provider organization from seeking other funds authorized under the CARES Act? (Added 5/29/2020)

There is no direct ban under the CARES Act on accepting a payment from the Provider Relief Fund and other sources, so long as the payment from the Provider Relief Fund is used only for permissible purposes and the recipient complies with the Terms and Conditions. By attesting to the Terms and Conditions, the recipient certifies that it will not use the payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

Reporting Requirements. The Terms and Conditions suggest extensive reporting requirements¹¹ for the program.¹² In July, HHS provided additional clarity regarding the [reporting requirements](#). As part of the notice, HHS stated: “The purpose of this notice is to inform Provider Relief Fund (PRF) recipients that received one or more payments exceeding \$10,000 in the aggregate from the PRF of the timing of future reporting requirements.” These revised reporting requirements still have lowered the threshold – from \$150,000 in the Terms and Conditions to \$10,000 in the notice. On September 19, HHS released [additional details](#) regarding the specific reporting elements. Of note, with respect to the revenue losses, the reporting requirements state that “PRF payment amounts not fully expended on healthcare related expenses attributable to coronavirus are then applied to lost revenues, represented as a negative change in year-over-year net patient care operating income (i.e., patient care revenue less patient care related expenses for the Reporting Entity, defined below, that received funding), net of the healthcare related expenses attributable to coronavirus calculated under step 1. Recipients may apply PRF payments toward lost revenue, **up to the amount of their 2019 net gain from healthcare related sources. Recipients that reported negative net operating income from patient care in 2019 may apply PRF amounts to lost revenues up to a net zero gain/loss in 2020.**” (emphasis added) On October 22, HHS released a [memo](#) along with [revised](#) reporting requirements, which shift this requirement from a comparison of profit to changes in patient revenue. Specifically, it notes that “[r]ecipients may apply PRF payments toward lost revenue, up to the amount of the difference between their 2019 and 2020 actual patient care revenue.” This differs from the [initial](#) reporting requirements which focused on net profit but still retains the focus on comparing year over year instead of month over month.

As part of the September notice, HHS detailed the other sources of 2020 revenue to help ensure that any payments from the fund are not used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse. A short summary of the reporting requirements can be found [here](#). In early October, HHS further clarified on its [website](#) that any reimbursement for the uninsured portion would not count toward the \$10,000 threshold, given that those funds are not subject to the final reporting requirements.¹³ Shortly after the release of this information, HHS further [clarified](#) the timeframe for

¹¹ The Recipient shall submit reports as the Secretary determines are needed to ensure compliance with conditions that are imposed on this Payment, and such reports shall be in such form, with such content, as specified by the Secretary in future program instructions directed to all Recipients. Not later than 10 days after the end of each calendar quarter, any Recipient that is an entity receiving more than \$150,000 total in funds under the Coronavirus Aid, Relief, and Economics Security Act (P.L. 116-136), the Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123), the Families First Coronavirus Response Act (P.L. 116-127), or any other Act primarily making appropriations for the coronavirus response and related activities, shall submit to the Secretary and the Pandemic Response Accountability Committee a report. This report shall contain: the total amount of funds received from HHS under one of the foregoing enumerated Acts; the amount of funds received that were expended or obligated for reach project or activity; a detailed list of all projects or activities for which large covered funds were expended or obligated, including: the name and description of the project or activity, and the estimated number of jobs created or retained by the project or activity, where applicable; and detailed information on any level of sub-contracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 allowing aggregate reporting on awards below \$50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget. The Recipient shall maintain appropriate records and cost documentation including, as applicable, documentation required by 45 CFR § 75.302 – Financial management and 45 CFR § 75.361 through 75.365 – Record Retention and Access, and other information required by future program instructions to substantiate the reimbursement of costs under this award. The Recipient shall promptly submit copies of such records and cost documentation upon the request of the Secretary, and Recipient agrees to fully cooperate in all audits the Secretary, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions.

¹² The May 6 updates to the FAQs indicated that “HHS will provide guidance in the future about the type of documentation we expect recipients to submit. Additional guidance will be posted at <https://www.hhs.gov/provider-relief/index.html>.”

¹³ Key language is as follows:

these reporting requirements. All recipients must submit a report by **February 15, 2021**, and this can be a final report if all funds have been expended by December 31, 2020. Otherwise, the final report deadline is **July 31, 2021** for funds expended the first six months of 2021 (or June 30, 2021). The portal for report submission will be open as of **January 15, 2021**.

On November 2, HHS further [updated](#) its Reporting Requirements and its [FAQs](#). The new question¹⁴ highlights a significant clarification within the Reporting requirements. This update clarifies that any lost patient revenue is NOT offset by any funds received for coronavirus-related expenses. Therefore, now, to determine if a provider should retain any PRF funds, the provider will first determine any healthcare related expenses attributable to coronavirus that another source has not reimbursed and is not obligated to reimburse and then calculate any changes from 2019 in patient revenues. This clarification should ensure that most providers are eligible to retain a larger portion of the PRF funds.

With respect to the [reporting elements](#), per the language in the *Consolidated Appropriations Act, 2021*, as of January 15, 2021, HHS is allowing entities to use one of three methods for reporting revenue loss: (1) difference between 2019 and 2020 actual patient care revenue; (2) difference between 2020 budgeted and 2020 actual patient care revenue, provided that the budget was established prior to March 27, 2020 and provided that additional documentation is submitted; and (3) any reasonable method for calculating lost revenue provided that additional information is submitted and recognizing that this option will trigger an increased likelihood of an audit, along with additional timelines if HHS determines that the methodology is not reasonable. Further, if recipients do not expend PRF funds in full by the end of calendar year 2020, then the calculation related to revenue losses are different from 2020 and are not to exceed the difference between: (1) 2019 Quarter 1 to Quarter 2 and 2021 Quarter 1 to Quarter 2 actual revenue, or (2) 2020 Quarter 1 to Quarter 2 budgeted revenue and 2021 Quarter 1 to Quarter 2 actual revenue. In addition, the document updates information related to reporting responsibility of parent organizations and their subsidiaries.

Audit Requirements. In June 2020, the American Institute of Certified Public Accountant's Governmental Audit Quality Center (GAQC) issued a document to summarize how Uniform Guidance applies ("Single Audit" or other audit requirements) to new federal programs established due to the COVID-19 pandemic (the [Summary](#)). In recent updates to the FAQs,¹⁵ HHS has clarified the application of the Single Audit for the Provider Relief Fund

These final reporting requirements do not apply to:

- Nursing Home Infection Control distribution recipients
- Rural Health Clinic Testing distribution recipients
- Health Resources and Services Administration (HRSA) Uninsured Program reimbursement recipients

Separate reporting requirements may be announced in the future.

¹⁴ Full FAQ reads as follows:

At the bottom of page 1 of the reporting requirements announcement in PDF, Step 2 states "PRF payment amounts not fully expended on healthcare related expenses attributable to coronavirus are then applied to patient care lost revenues, net of the healthcare related expenses attributable to coronavirus calculated under step 1." Is the underlined language still applicable under the reporting requirements notice that HHS posted on October 22, 2020? (Added 11/2/2020)

No, healthcare related expenses are no longer netted against the patient care lost revenue amount in Step 2. A revised notice will be posted to remove this language.

¹⁵ Full FAQs read as follows:

Are Provider Relief Fund payments fund payment to non-Federal entities (states, local governments, Indian tribes, institutions of higher education, and nonprofit organizations) subject to Single Audit? (Modified 7/30/2020)

Provider Relief Fund General and Targeted Distribution payments (CFDA 93.498) and Uninsured Testing and Treatment

payments. Specifically, HHS notes that for all entities other than commercial, for-profit entities, the Single Audit applies if the entity otherwise **expends \$750,000 or more in federal awards**, including uninsured, targeted, and general PRF payments. For the commercial, for-profit entities, the entity has two options – (1) Single Audit; or (2) “a financial audit conducted in accordance with Generally Accepted Government Auditing Standards.”

In general, the objectives of a financial audit conducted in accordance with Generally Accepted Government Auditing Standards are to provide an opinion on whether an entity’s financial statements are presented fairly and to report on the adequacy of internal controls. Single Audits have additional objectives, including a determination that the auditee has complied with federal statutes, regulations, and terms and conditions of federal awards.

In reviewing the audit processes, if a provider is subject to the requirements, it would be best to consult with an accountant about whether the audit should be limited to entity that received the funds or encompass the entire organization (i.e., parent and subsidiaries), given that the FAQs are not clear on that matter.

In addition, HHS has also recently [clarified](#) that “[t]he Recipients of provider relief fund payments may be subject to auditing to ensure the accuracy of the data submitted to HHS for payment. Any Recipients identified as having provided inaccurate information to HHS will be subject to payment recoupment and other legal action. Further, all recipients of provider relief payments shall maintain appropriate records and cost documentation including, as applicable, documentation described in 45 CFR § 75.302 – Financial management and 45 CFR § 75.361 through 75.365 – Record Retention and Access, and other information required by future program instructions to substantiate that providers used all Provider Relief Fund payments appropriately. Upon the request of the Secretary, the Recipient shall promptly submit copies of such records and cost documentation and Recipient must fully cooperate in all audits the Secretary, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with applicable Terms and Conditions. Deliberate omission, misrepresentation, or falsification of any information contained in payment applications or future reports may be punishable by criminal, civil, or administrative penalties, including but not limited to revocation of Medicare billing privileges, exclusion from federal health care programs, and/or the imposition of fines, civil damages, and/or imprisonment.”

reimbursement payments (CFDA 93.461) to non-Federal entities are Federal awards and must be included in determining whether an audit in accordance with 45 CFR Part 75, Subpart F is required (i.e., annual *total federal awards expended* are \$750,000 or more). Audit reports must be submitted to the Federal Audit Clearinghouse electronically at <https://harvester.census.gov/facides/Account/Login.aspx>. (Requirements for audit of payments to commercial organizations are discussed in a separate question.)

Are Provider Relief Fund payments to commercial (for-profit) organizations subject to Single Audit in conformance with the requirements under 45 CFR 75 Subpart F? (Modified 7/30/2020)

Commercial organizations that receive \$750,000 or more in annual awards have two options under 45 CFR 75.216(d) and 75.501(i): 1) a financial related audit of the award or awards conducted in accordance with Government Auditing Standards; or 2) an audit in conformance with the requirements of 45 CFR 75 Subpart F. Provider Relief Fund General and Targeted Distribution payments (CFDA 93.498) and Uninsured Testing and Treatment reimbursement payments (CFDA 93.461) must be included in determining whether an audit in accordance with 45 CFR Subpart F is required (i.e., annual *total awards received* are \$750,000 or more). Audit reports of commercial organizations must be submitted directly to the U.S. Department of Health and Human Services, Audit Resolution Division at AuditResolution@hhs.gov.

Can my organization get an extension to the submission due date for audits? (Modified 7/30/2020)

Yes. The Office of Management and Budget (OMB) in OMB M-20-26, Extension of Administrative Relief for Recipients and Applicants of Federal Financial Assistance Directly Impacted by the Novel Coronavirus (COVID-19) due to Loss of Operations, dated June 18, 2020, provided non-Federal entities extensions beyond the normal due date to submit audit reports. Please see the OMB website for more details: <https://www.whitehouse.gov/omb/information-for-agencies/memoranda/>. Commercial organizations with questions about their ability to obtain extensions should email HRSA’s Division of Financial Integrity at SARFollowup@hrsa.gov.

Recoupment. Per the FAQs, HHS has not defined a recoupment process but contemplates doing so.¹⁶ The May 6 FAQ updates provide conflicting information regarding whether HHS will opt to recoup any “overpaid amounts.” First, the it states that “Generally, HHS does not intend to recoup funds as long as a provider’s lost revenue and increased expenses exceed the amount of Provider Relief funding a provider has received.”¹⁷ Separately, the document notes that “[i]f a provider believes it was overpaid or may have received a payment in error, it should reject the entire General Distribution payment and submit the appropriate revenue documents through the General Distribution portal to facilitate HHS determining their correct payment.”¹⁸

Salary cap. The funds provided cannot be used to “pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.” According to [OPM](#), Executive Level II is \$197,300 for 2020. A recent HHS FAQ suggests that the funds are subject to this restriction. The FAQ¹⁹ further clarifies that

¹⁶ Full FAQ reads as follows:

How will HHS recoup funds from providers that are required to repay all or part of a Provider Relief Fund payment? (Added 5/29/2020)

HHS has not yet detailed how recoupment or repayment will work. However, the Terms and Conditions associated with payment require that the Recipient be able to certify, among other requirements, that it was eligible to receive the funds (e.g., provides or provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19) and that the funds were used in accordance with allowable purposes (e.g., to prevent, prepare for, and respond to coronavirus). Additionally, recipients must submit all required reports as determined by the Secretary. Non-compliance with any Term or Condition is grounds for the Secretary to direct recoupment of some or all of the payments made. HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately.

¹⁷ Full FAQ reads as follows:

Does HHS intend to recoup any payments made to providers not tied to specific claims for reimbursement, such as the General Distribution payments? (Added 5/6/2020)

The Provider Relief Fund and the Terms and Conditions require that recipients be able to demonstrate that lost revenues and increased expenses attributable to COVID-19, excluding expenses and losses that have been reimbursed from other sources or that other sources are obligated to reimburse, do not exceed total payments from the Relief Fund. Generally, HHS does not intend to recoup funds as long as a provider’s lost revenue and increased expenses exceed the amount of Provider Relief funding a provider has received. HHS reserves the right to audit Relief Fund recipients in the future to ensure that this requirement is met and collect any Relief Fund amounts that were made in error or exceed lost revenue or increased expenses due to COVID-19. Failure to comply with other Terms and Conditions may also be grounds for recoupment.

¹⁸ Full FAQ reads as follows:

What if my payment is greater than expected or received in error? (Modified 8/4/2020)

Providers that have been allocated a payment must sign an attestation confirming receipt of the funds and agree to the Terms and Conditions within 90 days of payment. In accordance with the Terms and Conditions, if you believe you have received an overpayment and expect that you will have cumulative lost revenues and increased costs that are attributable to coronavirus during the COVID-19 public health emergency that exceed the intended calculated payment, then you may keep the payment. If a provider does not have or anticipate having these types of COVID-19-related eligible expenses or lost revenues equal to or in excess of the Provider Relief Fund payment received, it should reject the payment in Provider Relief Fund Attestation Portal and return the entire payment. Please call the Provider Support Line at (866) 569-3522 (for TYY, dial 711) for step- by-step instructions on returning the payment and receive the correct payment when relevant.

¹⁹ Full FAQ reads as follows:

What is the definition of Executive Level II pay level, as referenced in the Terms and Conditions? (Added 5/29/2020)

The Terms and Conditions state that none of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other mechanism, at a rate in excess of Executive Level II. The salary limitation is based upon the Executive Level II of the Federal Executive Pay Scale. Effective January 5, 2020, the Executive Level II salary is \$197,300. For the purposes of the salary limitation, the direct salary is exclusive of fringe benefits and indirect costs. The limitation

“[f]or the purposes of the salary limitation, the direct salary is exclusive of fringe benefits and indirect costs. The limitation only applies to the rate of pay charged to Provider Relief Fund payments and other HHS awards. An organization receiving Provider Relief Funds may pay an individual’s salary amount in excess of the salary cap with non-federal funds.”

90 Days. HHS has made at least two changes to extend the time for attestation – press release on May 7 (which extended it to 45 days) and press release on May 22 (which extended it to 90 days). Recently, HHS updated the Terms and Conditions to conform with the 90-day requirement.

Tax status. HHS and IRS recently clarified the tax status of the funds received. In general, the funds are taxable. Non-profit entities should review the key FAQs closely.²⁰

Statutory Summary

Both the *CARES Act* and the *Paycheck Protection Program and Health Care Enhancement Act* used the same statutory language to describe the fund and the requirements of the fund.

Definition: “*eligible health care providers*” means public entities, Medicare or Medicaid enrolled suppliers and providers, and such for-profit entities and not-for-profit entities not otherwise described as the Secretary may specify, within the United States (including territories), that provide diagnoses, testing, or care for individuals with possible or actual cases of COVID–19.

Payments. Directs the Secretary of Health and Human Services to, on a rolling basis, review applications and make payments. The term “payment” means a pre-payment, prospective payment, or retrospective payment, as determined appropriate by the Secretary. That payments are directed to be made in consideration of the most efficient payment systems practicable to provide emergency payment.

Use of Funds. Funds are available for building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity.

only applies to the rate of pay charged to Provider Relief Fund payments and other HHS awards. An organization receiving Provider Relief Funds may pay an individual’s salary amount in excess of the salary cap with non-federal funds.

²⁰ Full FAQs read as follows:

May a health care provider that receives a payment from the Provider Relief Fund exclude this payment from gross income as a qualified disaster relief payment under section 139 of the Internal Revenue Code (Code)? (Added 7/10/2020)

No. A payment to a business, even if the business is a sole proprietorship, does not qualify as a qualified disaster relief payment under section 139. The payment from the Provider Relief Fund is includible in gross income under section 61 of the Code. For more information, visit the Internal Revenue Services’ website at <https://www.irs.gov/newsroom/frequently-asked-questions-about-taxation-of-provider-relief-payments>.

Is a tax-exempt health care provider subject to tax on a payment it receives from the Provider Relief Fund? (Added 7/10/2020)

Generally, no. A health care provider that is described in section 501(c) of the Code generally is exempt from federal income taxation under section 501(a). Nonetheless, a payment received by a tax-exempt health care provider from the Provider Relief Fund may be subject to tax under section 511 if the payment reimburses the provider for expenses or lost revenue attributable to an unrelated trade or business as defined in section 513. For more information, visit the Internal Revenue Services’ website at <https://www.irs.gov/newsroom/frequently-asked-questions-about-taxation-of-provider-relief-payments>.

Application process. An eligible health care provider shall submit to the Secretary of Health and Human Services an application that includes a statement justifying the need of the provider for the payment and the eligible health care provider shall have a valid tax identification number.

Reports. Recipients are required to submit reports and maintain documentation as the Secretary determines are needed to ensure compliance with the required conditions.